

DEPARTMENT OF HEALTH  
TOWN HALL, 2 RENSRAW ROAD  
DARIEN, CONNECTICUT 06820-5397  
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## APPLICATION FOR ITINERANT FOOD SERVICE LICENSE

YEAR: \_\_\_\_\_

NAME OF COMPANY: \_\_\_\_\_

MODEL AND MAKE OF VEHICLE AND YEAR: \_\_\_\_\_

\_\_\_\_\_

LICENSE PLATE NUMBER: \_\_\_\_\_ COLOR OF VEHICLE: \_\_\_\_\_

VIN: \_\_\_\_\_

OPERATOR OF VEHICLE: \_\_\_\_\_

CLASS: \_\_\_\_\_ QFO: \_\_\_\_\_

### OWNER INFORMATION

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

ANNUAL FEE

\*\*\*Pay this Amount\*\*\*

\$ \_\_\_\_\_

SUBMITTED BY: \_\_\_\_\_ OWNER

Signature: \_\_\_\_\_

### MAKE CHECK PAYABLE TO DARIEN HEALTH DEPARTMENT

For Office Use Only:

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Check Number: \_\_\_\_\_ Receipt No. \_\_\_\_\_